Greater Kansas City Medical Society

3550 South 4th Street Trafficway, Suite 120
Leavenworth, Kansas 66048
c/o Vernon A. Mills, M.D.

Date:_____ Gender: □ male □ female

Name:_____
Last, first, middle

Practice name:_____ Phone:_____

Office:_____ Fax:_____
address city state zip

Home:_____ Phone:_____
address city state zip

Cell phone: _____ Preferred phone contact : □ office □ home □ Cell phone

For mailing, please use: □ office address □ home address □ e-mail address:_____

Birthdate: _____ birthplace: _____ spouse's name: _____

Medical school: _____ circle one: MD or DO date completed: _____

Residency program:_____ Date completed: _____

Medical specialty: _____ Secondary specialty: _____

Medical license: Kansas #_____ date:_____ Missouri #_____ date:_____

licenses held in other states:_____

board certification – name:_____ date: _____

PRACTICE HISTORY

List chronologically, beginning with most recent. If additional space is required, please attach addendum.

1 _____ dates: _____
office, group or institution from to

_____
address city state zip

2 _____ dates: _____
office, group or institution from to

_____
address city state zip

3 _____ dates: _____

office, group or institution — from — to

_____

address — city — state — zip

4 _____ dates: _____

office, group or institution — from — to

_____

address — city — state — zip

5 _____ dates: _____

office, group or institution — from — to

_____

address — city — state — zip

Members abide by the NMA Principles of Medical Ethics and the bylaws of the Greater Kansas City Medical Society. To assist us in upholding these standards, please provide answers to the following questions, sign and date.
If you answer yes to any of these questions, please attach full information

YES **NO**

☐ ☐ 1. Have you ever been convicted of fraud or a felony?

☐ ☐ 2. Has any action, in jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, Suspension, limitation, probation, or any Other imposed sanctions or conditions.

☐ ☐ 3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the information submitted in this application will be verified. I herby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society.

The forgoing information is true and complete.

signature: _____

date: _____